Workgroup 1: Access to Healthcare Services

Proposed Recommendations

Topic 1: Access to Medical Coverage - broader than Medicaid

1.A. Health Insurance Premium Payment (HIPP)

1.A.1. HHSC to provide greater clarification on what is considered cost effectiveness (*is there a formula that HIPP is using?*).

1.A.2. Families are having to mail/fax in 100s-1,000s of pages of Explanation of Benefits (both pharmacy and medical services). HHSC needs to provide greater clarification on what evidence is needed to prove cost effectiveness.

1.B. Children with Special Health Care Needs

1.B.1. Sufficient funding should be provided to keep the wait list clear for the Children with Special Health Care Needs Services Program.

Topic 2: Provider Network

2.A. Network Adequacy

2.A.1. Create network adequacy standards that require networks to have enough physicians to meet the needs of child members with developmental disabilities. HHSC must ensure that each Managed Care Organization (MCO) is contracted with an adequate number of primary and specialist physicians, developmental pediatricians, therapists, home health agencies and hospitals that care for children with disabilities.

2.A.2. List criteria in MCO contracts for their call center staff to be able to identify providers within their network that care for children with disabilities, behavioral and cognitive chronic disorders so they can adequately assist families, members, legally authorized representatives in identifying providers to meet their specialized needs.

2.A.3. Require MCOs to list in their provider directory medical personnel with information related to experience and expertise related to specific physical, behavioral, or cognitive diagnoses.

2.A.4. Create a Applied Therapy Analysis professional workgroup facilitated by HHSC to define criteria for licensing or certification of Applied Behavioral Analysis and develop a set of criteria to be used for development of the Medicaid Package of Services for all Medicaid eligible persons with Autism to ensure they receive all necessary services.

2.B. Preferred Provider Arrangements

2.B.1. Preferred provider arrangements can be used to ensure robust access to quality services and durable medical equipment while maintaining access to unique and specialty resources. HHSC should define clear requirements on how preferred provider arrangements may be utilized ensuring:

- Members are given a choice of two to three providers for specialty services and durable medical equipment including non-preferred provider arranged services.
- Members have the right to choose the best services or equipment that meets the medical necessity of the member regardless of provider arrangement with the MCOs.
- MCOs must submit all preferred provider arrangement contracts to HHSC for review and approval.
- MCO call center staff must inform members of non-preferred providers along with preferred providers available in the network.

2.B.2. Stop the implementation of a value-based purchasing model where a MCO designates a single provider for all therapy evaluations and/or designates a preferred provider for treatment services where prior authorization requirements are waived for families willing to use the preferred provider. This model eliminates freedom-of-choice for Medicaid beneficiaries. Designating a sole provider as the preferred provider for treatment services and waiving prior authorization requirements for families that use this provider may have the effect of creating an exclusive provider network. HHSC should require that any payment model implemented by a MCO be researched based, consider stakeholder input, maintain consumer access to services, and improve quality. HHSC should also ensure that accountability measures are in place.

2.C. Broaden Physicians

2.C.1. Mandate all teaching hospital systems require all practicing physicians participate in Medicaid. - Alternative recommendation made to increase Medicaid reimbursement rates by x percent - bring for council discussion.

Topic 3: Access to Physical, Occupational and Speech Therapy

3.A. HHSC should:

3.A.1. Monitor the impact of the cuts on access to care to not only include waiting lists for therapy from MCO's, but also from performing providers themselves. Monitor delays in the initiation of therapy services and assess MCO network adequacy by the actual staffing capacity of performing providers, especially in rural areas.

3.A.2. Measure the cost savings associated with changes to therapy policy and provide information to the public on the savings, to increase transparency through quality outcome measures and utilization review measures using best practices. Use the savings to restore some of the speech therapy rate cuts.

3.A.3. Continue to evaluate documentation requirements for prior authorizations across MCOs to ensure individuals access medically necessary services without discrimination or inconsistencies across plans.

3.A.4. Encourage MCOs to standardize prior authorization documentation requirements and provide guidance to plans on the advantages of greater uniformity including consistency, transparency, and clarity that lead to an improved understanding and compliance by providers. Standardization of prior authorization would include fewer delays initiating therapy services and a better understanding by providers and prescribing physicians of the prior authorization requirements. Need longer term study on uniform authorization.

3.A.5. Allow physicians to complete an attestation form to confirm an ongoing chronic condition warranting a continued need for therapy, in order to decrease administrative delays in authorization due to frequent office visits. This will in turn increase cost savings.

3.A.6. Review the Texas Medicaid Provider's Procedure Manual (TMPPM) for Therapy and Private Duty Nursing services and ensure language is incorporated into the manual that addresses the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirement that services correct or ameliorate conditions. HHSC and the Texas Medicaid Provider's Procedure Manual need to provide guidance to approve therapies at a level that support a child's continued level of functioning and prevent a condition from worsening. Authorization of therapies for children on STAR Kids should not be approved solely based on the child's demonstration of progress towards goals and the correction of a condition. In addition, HHSC should evaluate the TMPPM and MCO authorization processes for other differences which negatively impact children with STAR Kids compared to children with STAR.

3.A.7. Restore rates which support access to therapy services.

Topic 4: Medical Marijuana

4.A. Compassionate use

4.A.1. Evaluate access to the Compassionate Use Program in Texas and what modifications would facilitate equal access across the state.

4.B. Disparities between states

4.B.1. Authorize HHSC to conduct an evaluation of the current use of medical marijuana from other states, as well as identify stakeholder consensus on other beneficial uses beyond severe seizure disorders.

4.C. Discrepancies in access and law

4.C.1. Provide protections for families who are authorized for compassionate use of medical marijuana in other states.

Topic 5: Medical Transition for Transition Age Youth

5.A. Network adequacy

5.A.1. Create pay for performance incentives for adult practitioners to receive young adults with special health care needs including payment incentives for physicians that allow for longer appointment times needed to meet the needs of children and young adults with medically complex conditions.

5.A.2. Require MCOs to develop payment mechanisms to enable both pediatric and adult care providers to receive payment for medically necessary services concurrently during the transition process. A similar process has been established by the state of Pennsylvania in their Medicaid Managed Care Health Choices product. https://pealcenter.org/wp-content/uploads/2017/06/OPS_Memo_Information_1.pdf

5.A.3. Create network adequacy standards that require networks to have enough physicians to meet the needs of adult members with developmental disabilities. HHSC must ensure that each MCO is contracted with an adequate number of primary and specialist physicians, therapists, home health agencies and hospitals that care for children with disabilities over the age of 16, making certain that there is access to physicians and other providers who have experience and expertise in working with adults with chronic care needs.

5.A.4. HHSC should partner with physician organizations to provide education about transition, and evaluate if contract amendments between MCOs and physicians are necessary to ensure continuity until transition is accomplished. This will ensure pediatric providers do not age-out families before adult providers are found.

5.A.5. Require MCOs to list in their provider directory, adult medical personnel with information related to experience and expertise related to specific physical, behavioral, or cognitive diagnoses.

5.B. Transition clinics

5.B.1. Increase the availability of medical homes for youth transitioning to adult services by recruiting centers of excellence for transition across the state. Texas is fortunate to have a unique medical clinic for youth with disabilities as they transition into adult services in Houston, the Transition Medicine Clinic at Baylor College of Medicine. The council strongly recommends supporting the increase of these types of clinics as medical homes throughout Texas. Clinics like these provide medical care and social support services to the growing population of adolescents/young adults with a chronic childhood illness or disability as they move from pediatric to adult healthcare. The goal of the clinic is to prevent urgent healthcare crisis and to minimize the impact of a shrinking social support network that these patients and families have come to rely on in the pediatric healthcare system. This includes helping them overcome obstacles encountered in both adult Medicaid and private health insurance systems.

5.B.2. Define performance measures for MCOs for specialized Medical Home projects where they are required to incentivize providers to promote out of the box thinking; to create network structures where provider pediatric and adult groups work together like a consolidated clinic to provide improved services to transitioning youth with developmental disabilities, or behavioral and cognitive disabilities.

5.C. Improvements to transition process

5.C.1. Begin medical transition planning at age 12 instead of age 15. Aligns with the recommendations set forth by Got Transition. http://www.gottransition.org/

5.C.2. HHSC should adopt and implement the American Academy of Pediatrics consensus statement http://pediatrics.aappublications.org/content/110/Supplement_3/1304.short and Got Transition's Six Core Elements as best practices: http://www.gottransition.org/providers/index.cfm.

5.C.3. Develop and implement core knowledge and skills required of health care professionals to provide developmentally appropriate health care transition services. Incorporate core competencies into training and certification requirements for primary care and specialty residents. Provide incentives and additional funding for physicians and providers to provide services to this unique population; and base incentive payments based on healthcare outcomes.

5.C.4. HHSC should create a requirement in contract for transition service coordinators in STAR Plus that are assigned to a transition age youth between the ages of 21 to 26.

5.C.5. Require a medical transition process in STAR Health and STAR that is like the process required in STAR Kids for children.

5.C.6. Require MCO Transition Coordinators to have training in the following:

- Alternates to guardianship
- Supported decision making
- Creative housing options including shared living arrangements and host homes
- Supported employment
- Creating a network of support

5.C.7. Improve the transition of children from STAR Kids to STAR Plus by:

- Requiring the same 12-month STAR Plus transition process for children in Intellectual and Developmental Disability and YES as is required for children receiving services under Medically Dependent Children Program (MDCP), Private Duty Nursing, Personal Care Services and Community First Choice.
- Requiring transition calls and information packages to members and families from HHSC and/or MCOs one year, six months, three months and 30 days prior to the individual's 21st birthday.
- Beginning the STAR Plus MCO enrollment process for children moving from STAR Kids to STAR Plus from 30 days before their 21st birthday to 90 days prior to their 21st birthday to allow the young person and their family to research providers, choose an MCO and begin the handoff of information to the MCO.
- Defining transition planning requirements and reporting from STAR Kids and STAR Plus MCOs to support collaboration.

Topic 6: Access to In-Home Health Services

6.A. Provide guidance to MCO's on the following:

6.A.1. Documentation requirements essential to making a Private Duty Nursing prior authorization determination to avoid a process that is so burdensome to the provider or the physician that it causes gaps in service delivery or delays in authorizing or initiating services and to ensure that individuals can access medically needed services without discrimination or inconsistencies across plans.

6.A.2. The process for continuity of care authorizations to avoid "short auths" that only authorize Private Duty Nursing through the end of a current month due to an anticipated payor change on the first of the following month.

6.A.3. "Continuation of services" authorization for Private Duty Nursing when pending fair a hearing to ensure that these authorizations do not end prior to or on the fair hearing date forcing the individual and Private Duty Nursing provider to request a new prior authorization before the date of the fair hearing.

6.A.4. To encourage the expansion of Personal Care Services and registered nurse delegated services with the use of Unlicensed Assistive Personnel as an alternative to low acuity Private Duty Nursing services through value-based agreements, consider provider and parent/member education on what is considered "safe and appropriate" and increase funding for registered nurse delegated services sufficient enough to allow providers the financial means to increase training Unlicensed Assistive Personnel's who could perform skills that could be performed safely under registered nurse delegation.

Topic 7: STAR Kids

7.A. STAR Kids

7.A.1. Divert children from nursing facilities by allowing all children and young adults who have Supplemental Security Income and meet the Medically Dependent Children Program eligibility criteria entry into waiver services in STAR Kids or STAR Health with no wait. For those individuals who are on the interest list and do not have Supplemental Security Income, maintain at least the current level of effort to offer those individuals waiver services at the existing rate.

7.A.2. Offer children who have lost eligibility for Medicaid due to loss of Medically Dependent Children Program eligibility in STAR Kids, access to another 1915(c) waiver such as Community Living Assistance and Support Services (CLASS) or Home and Community-based Services (HCS). Not only have children lost eligibility for waiver services, some have lost access to critical health care and long-term services and supports such as Personal Care Services. Without these services children are at risk of unnecessary institutionalization in Intermediate Care Facilities and Nursing Facilities at a higher cost to the children, their families and Texas Medicaid.

7.A.3. Families must be provided timely notice of their right to seek an appeal and a Medicaid fair hearing when Medicaid services such as nursing, personal care services, and therapy are reduced or denied. We recommend the following:

- HHSC should examine the feasibility of modifying the 10-day notification rule for appeal from 10 calendar days to 10 business days.

- HHSC should work with the MCOs to ensure notifications for a denial or reduction in services goes out in the mail within one day of the date on the notification by the health plan.
- Require the notice to be delivered via registered mail to ensure the time frame is followed.
- HHSC should ensure the notices are written in plain language for families with detail on why the denial occurred, what is needed to meet medical necessity requirements, deadlines for the appeal, and information on maintaining the same level of service during the appeal and fair hearing process until a final determination is made.